

**TOWN/CITY OF \_\_\_\_\_**  
**BENEFIT DATA INFORMATION SHEET**  
**SAGadahoc COUNTY**

Date: \_\_\_\_\_

CDBG PROGRAM TYPE \_\_\_\_\_

The Town/City of \_\_\_\_\_ is currently preparing an application for Community Development Block Grant (CDBG) funds from the State of Maine, Department of Economic and Community Development. The proposed activities are to: \_\_\_\_\_

For the proposed activities, the CDBG program requires proof of providing benefit to low and moderate-income persons. Therefore, the community is surveying the potential beneficiaries to ensure compliance with the regulations of the CDBG Program.

Your response to the following questions is critical in finalizing the application process. All responses will be kept confidential and used solely for securing CDBG grant funds.

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Name (optional): \_\_\_\_\_

Survey # \_\_\_\_\_

Address: \_\_\_\_\_

Please place an "X" in the appropriate spaces pertaining to your family's size, annual income and makeup

<u>FAMILY SIZE</u>		<u>INCOME</u>	
1	\$30,750	Above _____	Below _____
2	35,150	Above _____	Below _____
3	39,550	Above _____	Below _____
4	43,900	Above _____	Below _____
5	47,450	Above _____	Below _____
6	50,950	Above _____	Below _____
7	54,450	Above _____	Below _____
8	57,950	Above _____	Below _____

**\*Read This Carefully\***

In determining total family income use your Total Adjusted Gross income for your household as reported on your most recent Federal Income Tax form.  
If you use Form 1040 – use line 33  
If you use Form 1040A – use line 19  
If you use Form 1040EZ – use line 4

**BENEFICIARY INFORMATION:**

**Family Race** indicate by putting an "X" on the appropriate line

White \_\_\_\_\_ Black/African American \_\_\_\_\_ Asian \_\_\_\_\_ American Indian/Alaskan Native \_\_\_\_\_  
Native Hawaiian/Other Pacific Islander \_\_\_\_\_ American Indian/Alaskan Native & White \_\_\_\_\_  
Asian & White \_\_\_\_\_ Black/African American & White \_\_\_\_\_  
American Indian/Alaskan Native & Black/African American \_\_\_\_\_ Other \_\_\_\_\_

**Family Make-up:** Enter number of elderly or severely disabled family members and indicate with an "X" if a female head of household is present

Number of Elderly: \_\_\_\_\_

Number of Severely Disabled: \_\_\_\_\_

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TO BE FILLED OUT BY INDEPENDENT VERIFIER: LMI \_\_\_\_\_ NON LMI \_\_\_\_\_

\_\_\_\_\_  
Signature of authorized official

\_\_\_\_\_  
Date